Comprehensive Care Partnership (CCP)
Enrollment Form

Policyholder Name: _____ Address: _____

PEIA ID Number: _____ _____

Insurance effective date: _____ _____

Daytime Phone: _____ E-mail: _____

Covered Individuals (Only individuals listed below will be enrolled)	**Date of Birth**	**Relationship to Policyholder (Self, Spouse, Child)**	**CCP Location** **Include Name of Facility and Provider ID Number**
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____
			Facility: _____ Provider ID Number: _____

I agree that the above-listed persons carried on my PEIA PPB Plan coverage will participate in the CCP program at the above-listed health care provider. I agree the above-listed person(s) will abide by the rules, policies and restrictions of the CCP program.

Policyholder signature: _____ Date: _____

Please return this form to: **WV PEIA, Attn: CCP, State Capitol Complex, 1900 Kanawha Blvd East, Charleston, WV 25305-0710.** Coverage in the CCP will be effective on the first day of the month following the month we receive your enrollment form, if received before the 25th of the month.